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	34G182	A. BUILDING _____ B. WING _____	C 10/11/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 10/10/24 to 10/11/24 for intake #NC00221585. The allegation was substantiated and deficiencies were cited.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to ensure clients are not subjected to mistreatment, neglect and abuse (W127) by another client. The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 out of 6 clients in the home (#1, #2, #4, #5 and #6) were not subject to peer to peer physical, verbal and psychological abuse. The findings are: Review on 10/10/24 of clinical reports for client #3's behaviors revealed the following incidents were recorded when other clients in the home were the targets of client #3's physical aggression.	W 127		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 127	Continued From page 1 4/10/24, Staff B revealed at 9:19am client #3 punched client #2 in the arm several times, while loading the van. 4/16/24, Staff E revealed at 8:47am client #3 argued with client #2 before hitting and spitting on her while on the van. Client #3 also got out of her seat on the van, and hit client #4 before staff could redirect her. 4/23/24, Staff F revealed at 6:02pm client #3 became very aggressive in the home, using profanity, throwing plates at the other clients, threatening to kill other clients and pulled an unidentified client's hair. 4/24/24, Staff B revealed at 9:40am client #3 hit client #2 at the day program. 5/14/24, Staff B revealed at 1:30pm client #3 would not separate herself from client #2 and hit her repeatedly before physically redirected by staff. 5/16/24, Staff E revealed at 7:57am client #4 was in the bathroom when client #3 became upset and started to kick the bathroom door and began yelling at client #4. Client #3 also ran to client #2 and began hitting and spitting on her. 6/4/24, Staff E revealed at 9:45am client #3 became verbally aggressive to clients #4 and #5 making threats and spat on client #4. Client #3 made a threat to kill all the clients. 6/13/24, Staff E revealed at 1:18pm client #3 got out of her seat on the van, to hit and spit on client #2 while pulling her hair.	W 127		

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W 127	Continued From page 2 6/28/24, Staff A revealed at 3:45pm client #3 was having a behavior, destroying property which included breaking the lamp of client #4. 7/31/24, Staff B revealed at 8:40am client #3 had behaviors on the van; and spat and hit client #2 in the face. 9/24/24, Staff B revealed at 9:32am client #3 was noncompliant and slapped client #2 and would not stop pulling client #2's hair. In addition on the following dates: 6/5/24, 6/28/24, 7/9/24, 8/1/14, 8/7/24 and 9/3/24 staff recorded they had to lock themselves along with the other five clients into the bedroom of clients #1 and #6 to ensure their safety from client #3, who was engaged in property destruction and aggressive behaviors. Review on 10/11/24 of the Monthly Behavior Log revealed client #3 did not meet her behavior goals to have 20 or fewer targeted behaviors a month. Six months out of eight months, client #3 had between 21 and 44 behaviors each month, with aggression being exhibited most often. Interview on 10/10/24 with Staff A revealed client #3 can be easily triggered by other clients for no apparent reason and will quickly escalate to aggression or property destruction. Staff A acknowledged that on 10/8/24 she secured the clients in the bedroom of clients #1 and #6 while client #3 was having behaviors and the clients were scared of her. Staff A revealed the behavior interventions in client #3's behavior support plan were not helpful when deployed and medications prescribed for her behaviors had no effect. Staff A	W 127		

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revealed she has witnessed client #3 aggressively target client #2 most often and said she was "very dangerous," threatening to kill staff and everyone else in the house.

Interview on 10/10/24 with Staff B revealed client #3 engaged in attention seeking behaviors, was very competitive with peers and easily triggered to become aggressive. Staff B has witnessed client #3 pick up any item to throw or hit others, often resulting in property destruction.

Interview on 10/10/24 with the Home Manager revealed client #3 has most of her behaviors upon awakening and will glare at other clients in the home before targeting them with aggression. The Home Manager revealed client #3's behaviors are unmanageable and her medications do not help to stop her behaviors. The Home Manager also revealed that lately client #3 has done a lot of property destruction to the home and needs a 1:1 staff but they are short staffed and cannot add anyone to work with her specifically.

Interview on 10/11/24 with the Behavior Specialist (BS) revealed she has worked with client #3 for two years focusing on her behaviors. The BS acknowledged there has been several revisions to her behavior support plan (BSP) and changes in her medications, to try to decrease her behaviors in the home, which have seen an increase this year. The BS revealed that all staff in the home have been trained to employ a physical restrictive hold on client #3 in order to remove her from an area, when she continues to be defiant to redirection by staff and continues to threaten the safety of herself and others. The BS also acknowledged she recommended in August

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W 127	Continued From page 4 2024 hiring a 1:1 to work with client #3 during the day shift, where the bulk of her aggression occurs but the facility has been unable to staff it. Interview on 10/11/24 with the Program Director (PD) revealed the staff were no longer using the token system in the home because it did not seem to effect client #3. The PD acknowledged they have been trying to decrease client #3's aggression toward peers by making changes to her BSP, medications and hoped to get a 1:1 staff in place. The QIDP confirmed the facility was approved funding a month ago to hire a 1:1 staff for client #3 but had been unable to hire anyone for the position. The PD acknowledged client #3 has less incidents when she received more individualized attention, and less likely to become jealous of other clients in the home, resulting in her targeting them. In that the facility failed to have an effective system to protect peer to peer aggression for an extended period of time, the team failed to take preventive more effective measures when client #3's behaviors were noted to steadily escalate, failed to ensure staff used the instructed behavior management techniques as well as failed to staff the home to ensure the implementation of the client's behavior support plan, a condition was determined relative to the facility's ability to protect its clients.	W 127		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.	W 186		

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W 186	Continued From page 5	W 186		

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure there were sufficient staff to assist 1 of 6 audit clients (#3) manage behaviors and afford more opportunities for leisure activities and active treatment objectives. The finding is:

Review on 10/10/24 of client #3's Individual Program Plan (IPP) on 7/26/24 and Behavior Support Plan (BSP) 4/18/24 recommended opportunities for 1:1 supervision to help decrease defined behaviors and targeting other individuals.

Continue review on 10/10/24 of client #3's Client Report of the behavior log revealed 166 incidents since April 2024 that documented her hitting, spitting on other clients in the home, throwing items at others, having aggressive behaviors on the van during transport, locking herself on the van, locking staff out of the home, destroying cabinets, patio doors, breaking windows in the home, pulling the fire alarms and kicking in doors. On six document occasions, staff resorted to locking themselves in the bedroom of clients #1 and #6 when client #3 could not be redirected from aggression and destroying property.

Interview on 10/10/24 with Staff A revealed client #3 can be easily triggered by other clients for no apparent reason and will quickly escalate to aggression or property destruction. Staff A acknowledged that on 10/8/24 she secured the clients in the bedroom of clients #1 and #6 while client #3 was having behaviors and the clients were scared of her.

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W 186	Continued From page 6 Interview on 10/10/24 with Staff B revealed client #3 engaged in attention seeking behaviors, was very competitive with peers and easily triggered to become aggressive. Staff B has witnessed client #3 pick up any item to throw or hit others, often resulting in property destruction. Staff B revealed there was one staff working on third shift and Staff C sometimes requested for additional staff to come to work before first shift to assist when client #3 had unmanageable behaviors. Interview on 10/10/24 with the Home Manager revealed client #3 has most of her behaviors upon awakening and will glare at other clients in the home before targeting them with aggression. The Home Manager revealed client #3's behaviors are unmanageable and her medications do not help to stop her behaviors. The Home Manager also revealed that lately client #3 has done a lot of property destruction to the home and needs a 1:1 staff but they are short staffed and cannot add anyone to work with her specifically. Interview on 10/11/24 with the Behavior Specialist (BS) revealed she recommended in August 2024 hiring an 1:1 to work with client #3 during the day shift, where the bulk of her aggression occurs but the facility had been unable to staff it. Interview on 10/11/24 with the Program Director (PD) revealed they have been trying to decrease client #3's aggression toward peers by making changes to her BSP, medications and hoped to get a 1:1 staff in place. The QIDP confirmed the facility was approved funding a month ago to hire an 1:1 staff for client #3 but had been unable to hire anyone for the position. The QIDP	W 186		

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W 186	Continued From page 7 acknowledged client #3 has less incidents when she received more individualized attention, and less likely to become jealous of other clients in the home, resulting in her targeting them.	W 186		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff implemented the facility's behavior management training to prevent, de-escalate and intervene with behavior incidents that threatened the safety for 6 of 6 clients (#1,#2, #3, #4, #5 and #6) in the home. The finding is: Observation on 10/10/24 of video surveillance in the home on 10/9/24 at 4:15pm displayed client #3 slamming the kitchen cabinets and walked passed the medication room to her bedroom. Staff A appears in the hallway, pointing her finger at client #3 who is out of frame. Staff A stood in the hall having an extended conversation with client #3. It did not appear that Staff A's techniques were de-escalating the behavior giving client #3 repeated verbal prompts from a distance. Review on 10/10/24 of client #3's behavior support plan, revised April 2024 revealed she had the opportunity to earn a token after each shift for not exhibiting any of her targeted behaviors, that were to be reduced. If client #3 did not earn a token because of the behavior, she would be restricted for 24 hours from using an electronic or	W 193		

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lose a privilege for an outing.

Review on 10/10/24 of the Clinical Report from April 2024 documented 166 behavioral incidents with client #3 pulling fire alarms, destroying property, assaulting other clients and staff on the van, locking staff out of the house, locking staff and clients out of the van, picking up furniture to throw at others, breaking the windows to the patio door and back door, slamming cabinets, spitting and hitting others and kicking in doors. Twice the fire department responded to client #3's behaviors in the home and on the van. Staff physically restraining client #3 during these incidents were used very sparingly, with staff opting to locked clients with them in a bedroom until client #3 calmed down.

Interview on 10/10/24 with Staff A revealed client #3's behaviors can quickly escalate to aggression or property destruction. Staff A acknowledged that on 10/8/24 she secured the clients in the bedroom of clients #1 and #6 while client #3 was having behaviors and the clients were scared of her. Staff A revealed she has witnessed client #3 aggressively target client #2 most often and said she was "very dangerous," threatening to kill staff and everyone else in the house.

Interview on 10/10/24 with Staff B revealed she has witnessed client #3 pick up any item to throw or hit others, often resulting in property destruction. Staff B revealed she did her best to try her best to keep client #3 from hurting other clients by trying to manage her behaviors on the hall near her bedroom away from the other clients.

Interview on 10/10/24 with the Home Manager

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revealed client #3's behaviors are unmanageable and her medications do not help to stop her behaviors. The Home Manager also revealed that lately client #3 has done a lot of property destruction to the home and needs a 1:1 staff but they are short staffed and cannot add anyone to work with her specifically.

Interview on 10/11/24 with the Behavior Specialist (BS) revealed she has worked with client #3 for two years focusing on her behaviors. The BS acknowledged there has been several revisions to her behavior support plan (BSP) and changes in her medications, to try to decrease her behaviors in the home which have seen an increase this year. The BS revealed that all staff in the home have been trained to employ a physical restrictive hold on client #3 in order to remove her from an area, when she continues to be defiant to redirection by staff and continues to threaten the safety of herself and others. She also revealed that she was unaware staff were no longer using the token system and wanted it to continue in order for client #3 to receive more social praise for good behaviors at the end of each shift. The BS acknowledged she would like to see staff become more patient with client #3 so she can earn more tokens and not have so many repeated restrictions. The BS continued by expressing she also wanted staff to use their facility's behavior management training more to de-escalate client #3 quicker when she first exhibited target behaviors so that the behaviors would not interfere with her desire to engage in more 1:1 programs and leisure activities. The BS confirmed she recommended in August 2024 hiring a 1:1 to work with client #3 during the day shift where the bulk of her aggression occurs but the facility has been unable to staff it.

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W 193	Continued From page 10 Interview on 10/11/24 with the Program Director revealed he was one of the instructors for the facility's behavior management training and that all staff working with client #3 in the home have been trained to use the techniques. The Program Director acknowledged some staff need to be less confrontational when redirecting client #3.	W 193		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to ensure specific objectives necessary to meet the client's needs, to ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible (W249). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients. A condition was determined relative to the facility's inablity to protect its clients and supply sufficient staffing to manage client behaviors.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1)	W 196		

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W 196	Continued From page 11 Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that an aggressive and consistent active treatment program was provided for client #3. The findings are: Review on 10/10/24 of client #3's Individual Program Plan (IPP) on 7/26/24 and Behavior Support Plan (BSP) 4/18/24 recommended opportunities for 1:1 supervision to help decrease defined behaviors and targeting other individuals. A. Cross-reference W249. The team failed to assure that objectives were implemented and that sufficient interventions were available to meet identified needs relative to preventing peer to peer aggression, verbal and psychological abuse; and sufficiently de-escalate client #3 to prevent property destruction.	W 196		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

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W 249	Continued From page 12 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 audit clients (#3) received a continuous active treatment program consisting of needed interventions as identified in the individual program plan (IPP) relative to targeting others and sufficiently de-escalating client to prevent property destruction. Review on 10/10/24 of client #3's Individual Program Plan (IPP) from 7/26/24 revealed she preferred to have one-on-one interactions. The IPP also revealed client #3 displayed "strong emotions when upset" or when she felt she had been "wronged by another consumer in the home." Client #3 was described as getting agitated at times with peers and staff during social interactions as well as being a "competitive" person. Client #3's target behaviors were defiance, vocal agitation, bossing others and aggression with self-injurious behaviors. She needed to be monitored for patterns of inappropriate behaviors. Continued review of client #3's Behavior Support Plan (BSP) last revised on 4/18/24, revealed the objective of her plan decreased the criteria for client #3 to meet the goal to 8 to 20 or less per month. Client #3 was diagnosed with Intermittent Explosive Disorder and Bipolar II disorder. The targeted behaviors are defined as aggression,	W 249		

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self-injurious behaviors (SIB), bossing others, defiant behavior, property destruction, homicidal threats and vocal agitation. "If client #3 does not immediately stop exhibiting target behavior(s) in response to verbal warning, she will be redirected/escorted to an area of the group home or workshop where she is to remain until she is calm (at least 5 minutes without any target behavior occurrences).

Continue review of the BSP revealed the facility had authorized the use of approved restraints outlined in the facility's restrictive intervention program to be used in emergency situations to keep client #3, her peers and staff safe. She would be placed on restriction for any episodes of aggression/SIB or homicidal threats, losing access to electronic equipment or the opportunity to go on an outing, for 24 hours. Client #3 would have the opportunity to earn a token at the end of each shift for good behavior. Once 25 tokens were collected, she would earn a special outing with staff/management. Staff should prompt client #3 to begin activity, household chore and give her at least 1 minute to comply, without standing over her. If client #3 refused, staff will provide the least amount of physical assistance (soft touch to arm) to promote compliance. In the event that client #3 failed to calm down and behavior episodes continued for 5 minutes, or greater and she could possibly cause injury to herself and/or others, staff would contact the nurse to get permission to use a crisis medication for her behaviors.

Review on 10/11/24 of the Monthly Behavior Log since April 2024 revealed staff documented client #3 had 166 incidents where she exhibited defined targeted behaviors toward herself, other clients and staff. Client #3 was put on restriction often

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G182	A. BUILDING _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC EDGEWOOD GROUP HOME	77 EDGEWOOD DR CHOCOWINITY, NC 27817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and staff documented 7 times they secured the residents and themselves in a locked bedroom to be safe during her behavioral episodes.

Interview on 10/10/24 with Staff A revealed client #3 can be easily triggered by other clients for no apparent reason, or requests to do chores and will quickly escalate to aggression or property destruction. Staff A acknowledged client #3 was very competitive with the other clients in the home and gets upset if they do a chore first instead of her and will not wait her turn. Staff A also revealed it was difficult to engage client #3 in objectives for housekeeping or meal prep in the kitchen because she frequently spits on others or dishes when having a behavior. Staff A revealed the behavior interventions in client #3's behavior support plan were not helpful when used, especially the token system and medications prescribed for her behaviors had no effect.

Interview on 10/10/24 with Staff B revealed client #3 engaged in attention seeking behaviors, was very competitive with peers and easily triggered to become aggressive. Staff B has witnessed client #3 pick up any item to throw or hit others, often resulting in property destruction.

Interview on 10/10/24 with the Home Manager revealed client #3 has most of her behaviors upon awakening and will glare at other clients in the home before targeting them with aggression. The Home Manager revealed client #3's behaviors are unmanageable and her medications do not help to stop her behaviors. The Home Manager also revealed that lately client #3 has done a lot of property destruction to the home and needs a 1:1 staff but they are short staff cannot add anyone to work with her

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W 249	Continued From page 15 specifically. Interview on 10/11/24 with the Behavior Specialist (BS) revealed she has worked with client #3 for two years focusing on her behaviors. The BS acknowledged there has been several revisions to her behavior support plan (BSP) and changes in her medications, to try to decrease her behaviors in the home which have seen an increase this year. The BS revealed that all staff in the home have been trained to employ a physical restrictive hold on client #3 in order to remove her from an area, when she continues to be defiant to redirection by staff and continues to threaten the safety of herself and others. She also revealed that she was unaware staff were no longer using the token system and wanted it to continue in order for client #3 to be most successful in working toward the goal of receiving social praise for good behaviors at the end of each shift. The BS acknowledged she would like to see staff become more patient with client #3 so she can earn more tokens and not have so many repeated restrictions. The BS continued by expressing she also wanted staff to use their facility behavior management training more to de-escalate client #3 quicker when she first exhibited target behaviors so that the behaviors would not interfere with her desire to engage in more 1:1 programs and leisure activities. The BS confirmed she recommended in August 2024 hiring a 1:1 to work with client #3 during the day shift where the bulk of her aggression occurs but the facility has been unable to staff it. Interview on 10/11/24 with the Program Director (PD) revealed the staff were no longer using the token system in the home because it did not seem to effect client #3. The PD acknowledged	W 249		

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W 249	Continued From page 16 they have been trying to decrease client #3's aggression toward peers by making changes to her BSP, medications and hoped to get a 1:1 staff in place. The QIDP confirmed the facility was approved funding a month ago to hire a 1:1 staff for client #3 but has been unable to hire anyone for the position. The PD acknowledged client #3 has less incidents when she received more individualized attention, and less likely to become jealous of other clients in the home, resulting in her targeting them. In that the facility failed to revise the IPP and BSP when client #3's defined targeted behaviors continued to escalate, the team failed to reintegrate the behavior specialist in the treatment plan to redevelop a more effective token system to encourage client #3 to strive for more social praise to retain her privileges and failed to ensure staff fostered more opportunities for active treatment objectives instead of contnously issuing restrictions due to disruptive behaviors. These factors determined a condition was present relative to the facility's ability to fully implement the IPP and BSP as written to produce the best programs for client #3.	W 249		